# MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

**Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.**

| | | |
|---|---|---|
| ☐Yes | ☐No | Are you currently under a physician's care? |
| ☐Yes | ☐No | Have you ever been hospitalized or had a major operation? |
| ☐Yes | ☐No | Have you ever had a serious head, neck, or jaw injury? |
| ☐Yes | ☐No | Are you taking any medications, pills, or drugs? **If yes, please complete a medication list on the back of this form.** |
| ☐Yes | ☐No | Are you taking **BLOOD THINNERS**? |
| ☐Yes | ☐No | Do you take, or have you taken, Phen-Fen or Redux? |
| ☐Yes | ☐No | Have you EVER taken Fosamax, Boniva, Actonel or ANY other medicines containing **BISPHOSPHONATES** For **OSTEOPOROSIS**? |
| ☐Yes | ☐No | Do you use tobacco? Smoke? Dip? |
| ☐Yes | ☐No | Do you use controlled substances? |
| ☐Yes | ☐No | Do you have bleeding problems after surgery or having a tooth pulled? |

**DO YOU CURRENTLY HAVE, OR HAVE YOU HAD, ANY OF THE FOLLOWING?**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| ☐ | ☐ | AIDS/HIV/Venereal Disease | ☐ | ☐ | Kidney problems or dialysis |
| ☐ | ☐ | Alzheimer's Disease | ☐ | ☐ | Lung disease, emphysema, breathing disorders |
| ☐ | ☐ | Arthritis/Gout/Rheumatism | | | |
| ☐ | ☐ | Artificial Joints (hip or knee) | ☐ | ☐ | Psychiatric care |
| ☐ | ☐ | Blood disorders, anemia | ☐ | ☐ | Stroke, convulsions, seizures, fainting spells |
| ☐ | ☐ | Cancer, tumors, radiation, chemotherapy | | | |
| ☐ | ☐ | Diabetes | **WOMEN ONLY** | | |
| ☐ | ☐ | Drug addiction or chemical dependency | ☐ | ☐ | Are you pregnant? |
| ☐ | ☐ | Excessive bleeding after surgery or having a tooth pulled | ☐ | ☐ | Do you take birth control? |
| | | | ☐ | ☐ | Are you nursing? |
| ☐ | ☐ | Glaucoma or other eye problems | | | |
| ☐ | ☐ | Heart disease, heart attack, angina, surgery, Pacemaker, irregular heartbeat | **CHILDREN ONLY** | | |
| | | | ☐ | ☐ | Eye, ear, nose, throat problems |
| ☐ | ☐ | Hepatitis, jaundice, liver disease | ☐ | ☐ | Do you have a cold or flu? |
| ☐ | ☐ | High/Low blood pressure | | | |

**ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?**

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Sulfa Drugs ☐ Local anesthetics
☐ Acrylic ☐ Metal ☐ Latex ☐ Other: _____

**For joint replacements:** Have you ever taken antibiotics prior to dental treatment? ☐Yes ☐No
If yes, what?

_____

Do you have any other diseases/problems not listed above?_____

_____

Athens DENTAL SERVICES

**Physician's Name:** _____
**Address:** _____
**Phone:** _____

**Preferred Pharmacy:**

**Phone #:**

## MEDICATION LIST

**If you are taking any medications, please complete this form.**

| Medication | When I take it | Dose | Other Instructions |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| **Date of last cleaning:** | | **Date of last x-rays:** | |

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____DATE _____

**For Staff use only:**

| Date | Reviewed by: | Date | Reviewed by: | Date | Reviewed by: |
|---|---|---|---|---|---|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |